Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund 2022/23

Southwark

Narrative template

Draft v1.4 15/9/22

Note on timing of BCF Plan

The BCF plan is required to meet the requirements set out in national BCF planning guidance, which include a strong focus on the integration of services to improve outcomes, by supporting people to live in their own home, avoiding admission to hospital and care homes and ensuring support for hospital discharge is timely and effective.

In the absence of national planning guidance at the start of 2022/23, partners agreed to roll over much of the 2021/22 BCF plan (agreed by the Health and Wellbeing Board in November 2021). Provisional agreements were also made on the use of anticipated uplifts to address cost pressures and fund new schemes, all subject to the guidance being issued and plans receiving assurance. This approach was presented to the Health and Wellbeing Board in July 2022.

The planning guidance was issued on 19 July with a submission date of 26 September and these templates reflect this guidance. Whilst the guidance did not introduce changes that were deemed to require a review of the provisional funding decisions, there was a change in the emphasis and required content of narrative plans and the introduction of analysis of demand and capacity in Intermediate Care.

Contents:

1. Cover

Health and Wellbeing Board(s): Southwark

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils): Partnership Southwark members including Integrated Care Board, Southwark Council Public Health, Adults and Children's Services, Housing, Mental Health, Acute and Community Trusts and VCS.

How have you gone about involving these stakeholders? Engagement via Partnership Southwark and Health and Wellbeing Board discussions on strategy, and underpinning engagement on Partnership Southwark strategies including the Recovery Plan.

2. Executive summary

The Better Care Fund (BCF) is a pooled budget held between the council and the NHS that funds a range of core community based health and adult social care services. It was originally formed in 2015/16 by consolidating a range of existing funding streams for health and social care. It is a mandatory pooled budget to which the NHS and Council are required to make stipulated minimum contributions, with minimum ringfenced amounts to be spent on social care and health. The value of the BCF for 2022/23 is £48.7m, including £2.7m new additional funding above the minimum required level.

Key BCF priorities for 2022/23

The high-level priorities for the BCF are unchanged from previous plans that have been rolled forward into 2022/23. These are to provide funding for a range of out of hospital services to provide integrated person centred integrated care that will:

- Support people to live independently and safely in their own home
- Provide community support that prevent or delay people from needing higher levels of support
- Prevent avoidable admissions to hospital and care homes
- Support timely and effective transfers of care from hospital
- Improve population health and wellbeing outcomes and help tackle health inequalities by targeting resources at those most in need of support

More specifically for the current year, there are key system priorities that the BCF is closely aligned to:

- supporting the bedding in of the South East London Integrated Care System, including the Integrated Care Board Southwark borough team and the formalised **Partnership Southwark** arrangements, which were formally established on 1st July. In particular, our key priority is supporting the Partnership Southwark place-based programme for the development of integrated health and care services to improve population health
- supporting a reduction in health inequalities in line with the refreshed **Health and Wellbeing Strategy**, and aligned to the future **Southwark Health and Care Plan,** so that the BCF Plan will respond to this and feed into the South East London integrated care plan
- strengthening the **alignment of resources** and shared understanding of collective budgets across Partnership Southwark by considering further expansion of the BCF pooled budget and assisting the further development of the joint commissioning approach
- consolidating progress on the Partnership Southwark Recovery Plan with particular focus on **Age Well and Care Well workstreams**, building on the learning from the pandemic
- support further development of the **neighbourhood model** to promote integrated multi-disciplinary working focussed on outcomes and community needs
- strengthen whole **system resilience** in the face of anticipated intensive pressures, particularly over the winter period, including pressures arising from demand

(including possible flu, covid and cost of living pressures), cost pressures, workforce and funding issues.

- continued improvement to the **hospital discharge system,** including the development of the multi-disciplinary internal flow hubs and home first/ discharge to assess, reducing delayed transfers of care and avoidable long lengths of stay. This will both improve outcomes for patients and increase acute capacity.
- develop the support offer for **unpaid carers** using BCF resources as set out in section 6.

Changes to National BCF Priorities

As set out in section 5, the local priorities of the BCF also align to the revised national statement of BCF objectives set out in the July planning guidance to:

- **Enable people to stay well, safe and independent at home for longer**
- **Provide the right care in the right place at the right time**

Key changes to BCF budgets - 2022/23

A full summary of BCF budget changes since 2021/22 is set out in annex 1.

Although the BCF predominantly consists of schemes and budgets that have rolled forward from previous years there are new features to note for 2022/23:

Additional Contributions by the ICB and Council

In previous years the total value of the BCF has been set locally at the minimum level for Southwark under national planning guidance, this being the mandatory contribution of the council iBCF (Improved Better Care Fund) grant, and disabled facilities grant plus the minimum NHS contribution set by government formula. For 2022/23 it was agreed to exercise the option to add additional voluntary contributions above the minimum, adding services and their budgets that fit well within the BCF, thereby creating a larger pooled budget covering a greater proportion of the "Southwark £". For 2022/23 the approach is being piloted with an additional £2.6m of existing spend being moved into the BCF, as set out in table 1 overleaf.

It should be noted that some of the budgets being brought into the BCF relate to areas that for historical reasons were part funded by the BCF and part funded from organisations' (Council and ICB)/CCG) base budgets. The wider pooling rationalises this by making the service fully BCF funded (e.g. community equipment and telecare).

The addition of the community health falls service to the BCF reflects the importance attached to developing integrated approaches to falls prevention, a priority within the Age Well workstream.

Table 1: Additional contribution to the BCF above minimum - 2022/23

Additional council contributions:	**£000**
Council	
community equipment:	247
telecare:	445
Voluntary sector prevention:	483
Voluntary sector carers:	113
Total council:	**1,287**
CCG/ICB	
Community equipment:	1,201
@home community health:	191
Falls service:	821
Adjustments out:	(900)*
Total CCG/ICB:	**1,312**
Grand total additional contributions	**2,600**

*Note: The NHS growth is offset by £900,235 of service budgets transferred out of the BCF. This is because the ICB has changed the funding route for enhanced primary care access, which was part funded from the BCF but has been transferred directly to related Primary Care Network (PCN) budgets as part of an overall rationalisation. The previous budget for a care home pharmacist has also been transferred directly to the PCN budget as part of the wider PCN contract. Both services will be unaffected by this change. The Self-management budget has also been reduced by £100k to reflect actual spend although the required amount will be funded when services are re-commissioned.

Use of inflationary uplifts

The BCF Guidance confirmed annual uplifts in line with expected values that the BCF Planning Group had previously considered. The approach has been to target growth on agreed priority areas as follows:

Table 2: Use of annual uplift to CCG contribution (5.66%)

Council	**£'000**
Hospital discharge – discharge to assess:	250
Reablement OT team:	456
Reablement and nursing care home packages:	263
Telecare:	58
Total (Council)	**1,027**
CCG	
Enhanced rapid response and @home	362
Integrated community equipment growth	26
Tariff uplift neuro-rehab/EIS	9
Total (CCG)	**398**
Total uplift of CCG contribution	**1,424**

Table 3: Use of uplift in IBCF grant:

Council	**£'000**
Flexi Care	**525**

The iBCF grant is received by Councils for the provision of adult social care that is required to be pooled in the BCF. The £524,768 3% uplift in the IBCF grant has been assigned to Flexi Care:

Flexi Care (IBCF growth funding 2022/23)

Southwark's Housing and Social Care Partnership Board have agreed a new model of housing and care termed the provision 'Flexi Care'.

The Vision for Flexi Care is *'A community and neighbourhood approach to care and support that is delivered in an innovative, flexible and dynamic way'*

The aim of Flexi Care is to provide high quality and flexible care and support provision to residents, directed at those whose general needs housing is not adaptable to their care requirements. Allowing them to remain independent and engaged with the local community and 'flexing' their care and support based on their changing needs

The cohort of patients currently supported via the schemes are those aged 40 and upwards and capable of independent and semi-independent living. All residents are required to sign a tenancy agreement and will need capacity to do so. We support a range of people from low to high needs based on a banding system.

A full analysis of BCF budget changes between 2021/22 and 2022/23 is set out in **annex 1.**

3. Governance arrangement for the BCF

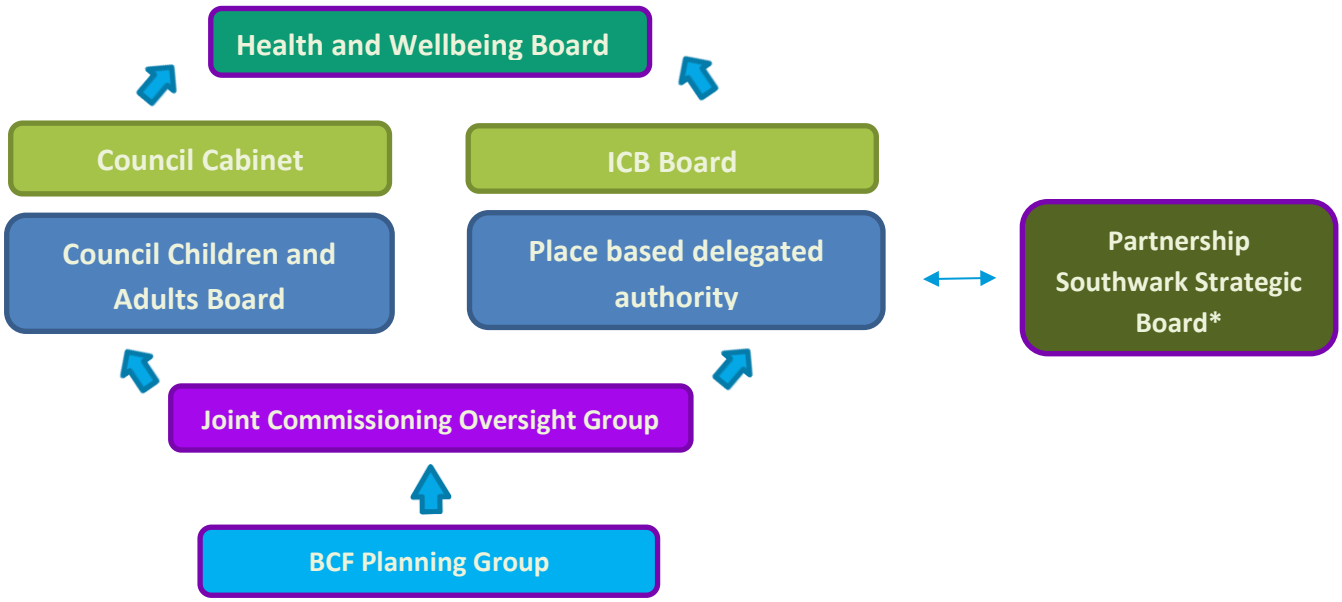
The BCF is agreed between the council and the ICB prior to approval by the Health and Wellbeing Board. After a draft has been agreed through the BCF Planning Group in consultation with stakeholders it is formally agreed through each organisation's respective governance requirements, then presented to the Health and Wellbeing Board. It is also subject to approval through a national BCF assurance process before being formally agreed.

The pooled budget arrangements are governed by a Section 75 agreement between the council and the CCG/ICB which sets out shared responsibilities to implement the planned spending as agreed. This Section 75 agreement is formally signed after the national approval letter. The BCF is subject to quarterly and year end reporting to NHSE, reviewed internally and agreed by the council and ICB before submission. Each scheme in the BCF is assigned a lead organisation responsible for the expenditure on that budget which is managed within the governance arrangements of the lead organisation.

In Southwark the BCF Planning Group has been set up to agree plans and oversee the high-level monitoring of the BCF on behalf of the Health and Wellbeing Board and to agree any changes to the use of funding. This group includes the Director of Adult Social Care, the council's Director of Commissioning for Children's and Adults and the ICB's Chief Operating Officer for Southwark on behalf of the Place Executive Lead as well as Finance leads.

Under revised place based governance arrangements following the formal establishment of the ICB a new Joint Commissioning Oversight Group has been established covering health, public health, adults and children's social care joint commissioning arrangements. The BCF Planning Group is a sub-group of this group. The diagram below is for illustrative purposes to provide context for the description of governance arrangements.

Governance Arrangements for the Southwark BCF



* Partnership Southwark Strategic Board helps shape the future strategic direction of the BCF as part of the delegation of ICB governance to local care partnerships.

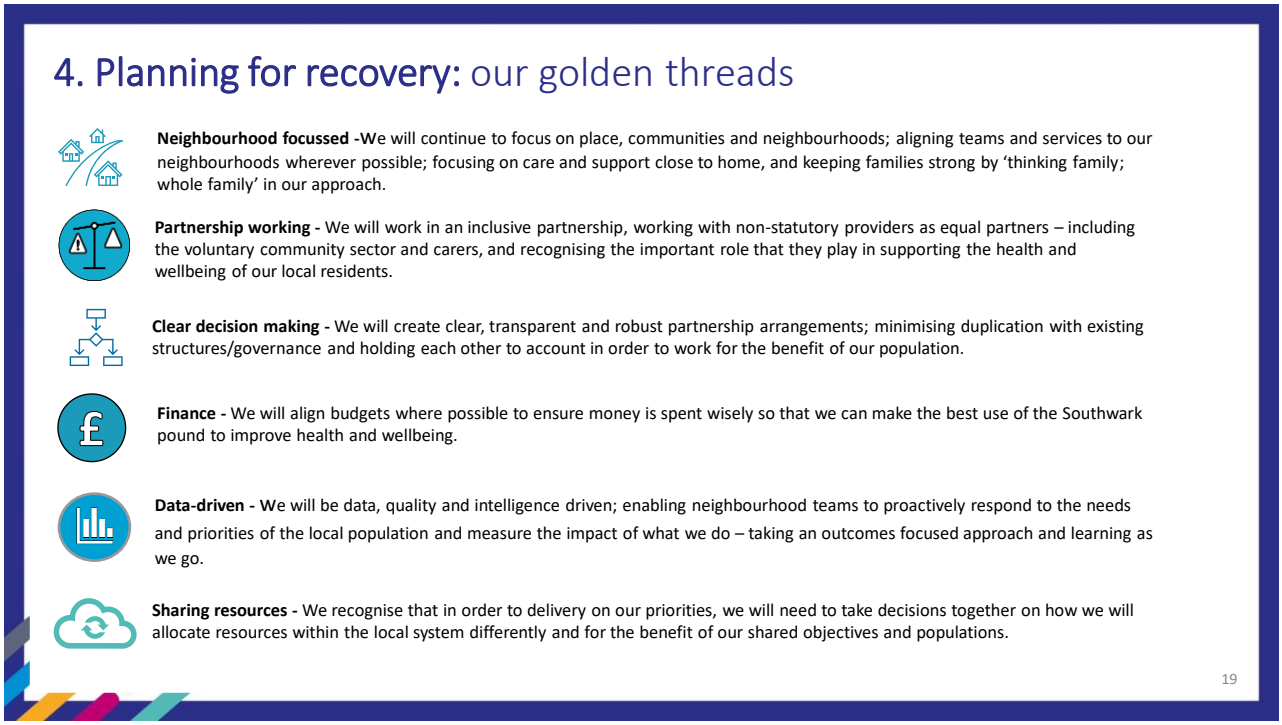
4. Overall BCF plan and approach to integration

Note: Following the formal establishment of Partnership Southwark as a sub-committee within the new SEL ICS structure from 1 July 2022 there will be a new **Southwark Heath and Care Plan** for the integration of health and care which partners will be working on during 2022/23. This plan will be focussed on the delivery of the recently refreshed **Health and Wellbeing Strategy** which is a key foundation to our approach to integration and joint commissioning, as set out in section 6. In the interim the approach to integration will be as set out in the Partnership Southwark Recovery Plan below:

The overall approach to integration in Southwark is driven through our local care partnership, Partnership Southwark. The partnership was first formed in May 2019 and brings together a range of health, care and anchor organisations with a view to working together with non-statutory providers and service users/carers in our communities. The overarching aim is to better join up services and tackle the causes of inequality and improve the health and wellbeing of Southwark residents. Partnership Southwark's Recovery Plan, which was signed off by the Partnership and Health and Wellbeing Board in September 2020, built on the work of the partnership pre-pandemic. It sought to use the experience of the first wave to reframe the partnership's work programme with a stronger focus on targeted approaches to addressing inequalities and a quadruple aim of:

Improving population health outcomes and reducing inequalities	Enhancing people's experience of care services and reducing unwarranted variation
Securing a financially sustainable health and care economy	Enabling compassionate care and supporting the health and wellbeing of our staff

Aside from short term recovery of services from COVID-19, the plan seeks to refocus our whole system efforts on tackling the health and wellbeing inequalities that were highlighted and exacerbated by the impact of COVID-19 on the population. The plan identifies 4 key population-based workstreams: **Start Well, Live Well, Age Well, Care Well** underpinned by key golden threads (overleaf):



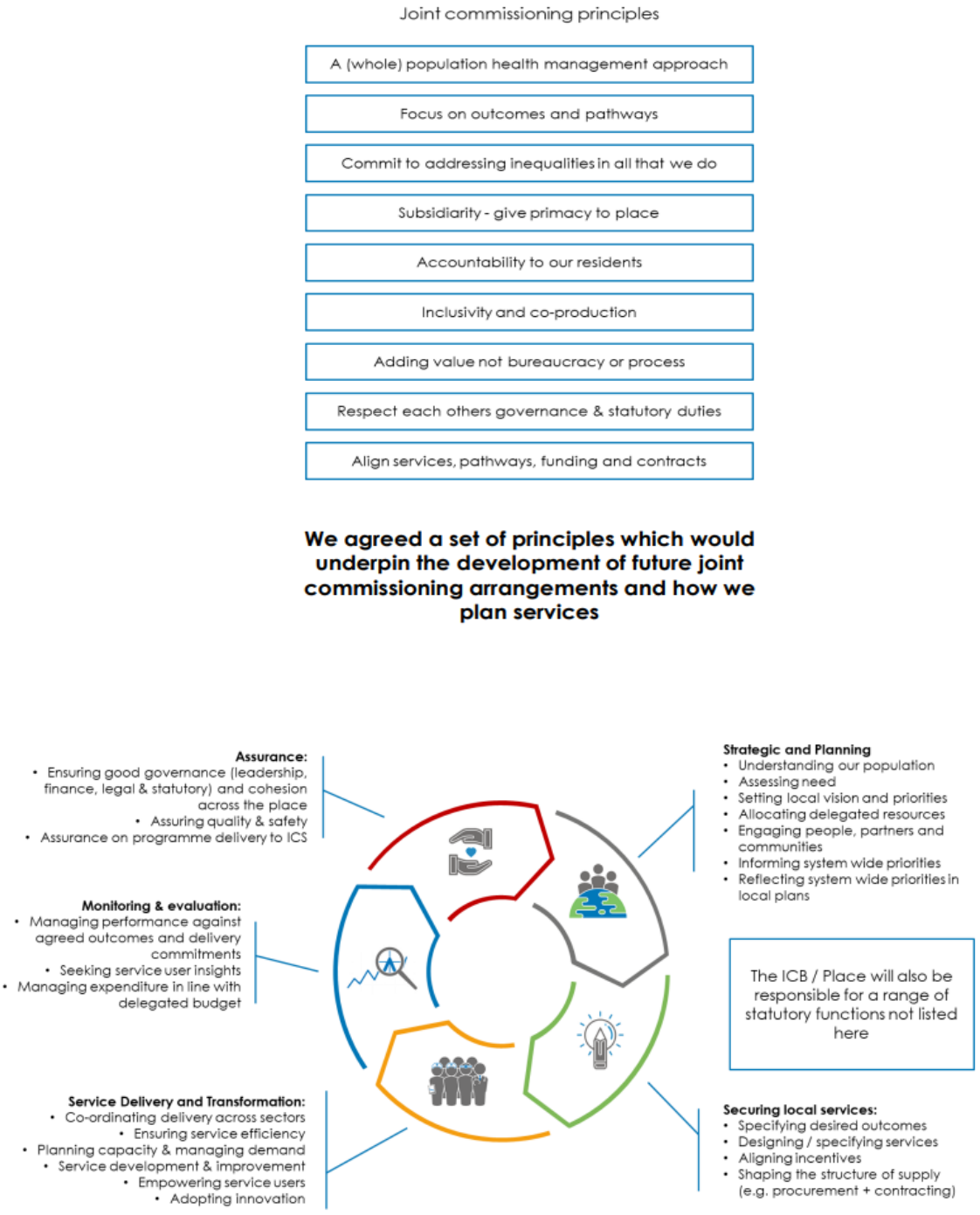
Approaches to joint/collaborative commissioning

Southwark council and the ICB have a well-established joint commissioning structure with teams responsible for delivering joint programmes to improve outcomes and address health inequalities for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded with a substantial contribution from the BCF. The primary care commissioning team is part of the overall structure (led by a joint-funded post) to help ensure cohesion, although the team is not jointly funded.

The joint commissioning teams works closely with the Partnership Southwark programme team that leads integrated programmes under the Start Well, Live Well, Age Well and Care Well programmes which are focussed on facilitating improved joint working between providers.

Building a consensus on further deepening the approach to integrated commissioning has been a key organisational development priority, supported by a Commissioning Strategy and Integration Board during 2021/22 which held workshops supported by external partners. This included agreeing key principles, a common framework for joint commissioning and planning progress against agreed "road map" milestones on an integration maturity matrix, and the development of integration demonstrator projects (see fig. 1). This work is ongoing under the new Partnership Southwark Strategic Board, overseen by the new Joint Commissioning Oversight Group and will be articulated through the development of the Partnership Southwark Health and Care Plan over 2022/23.

Fig 1: Joint Commissioning Principles and common framework for joint commissioning



Key principles of the Bridges to Health and Wellbeing Approach

Partnership Southwark has previously agreed an approach to joint commissioning for improved population outcomes referred to as the Bridges to Health and Wellbeing model that was developed following extensive engagement. Whilst it was decided not to take a prescriptive approach to applying the methodology to all programmes, the model provides guiding principles that apply to all integrated workstreams:

1	**Organising the population into coherent groups –** grouping the population according to similar patterns of health and care need (i.e. 'population segments') and associated relevant outcomes is a sound basis for developing a population based approach
2	**Agreeing outcomes for population groups** - the development of an agreed outcomes framework for each population group/ segment, like the approach used for the frailty, dementia and end of life segment, provides partners with a common focus
3	**Whole system approach to deliver the outcomes -** population health and wellbeing outcomes can only be fully achieved by all partners working together as a single Southwark system.
4	**The integrated service models need to be holistic and person focused** – health, care and universal services focussed on working together on the whole need of a person or population rather than service focused. Co-production of new service models with the public and the use of personalised outcomes for individuals in their multi-disciplinary plans is a key element of this.
5	**Prevention -** we need to shift resources to prevention if outcomes are to improve. This will mean sharing the costs, risks and rewards of investment in prevention opportunities we have identified.
6	**Providers and commissioners will need to work together in new ways -** with formal and informal alliances where necessary to deliver outcomes on which they are jointly accountable. This will include high levels of collaboration, trust, and data and intelligence sharing.
7	**Workstreams to be aligned to outcomes frameworks –** we need a structured approach to incorporating the delivery of improved outcomes into the way services are developed. This covers not just existing and proposed Partnership Southwark workstreams, but any relevant workstreams and "business as usual" services.
8	**Evidence based and driven by shared data –** The new integrated service models need to be based on in depth needs analysis using shared data on individuals and populations, mapping of existing services, gaps and opportunities, knowledge of best practice etc.
9	**Aligning resources and commissioning -** We need to consider all resources available for populations to improve outcomes and consider the best way of configuring them that is the best use of the "Southwark £".
10	**Commissioning for outcomes and contractual changes -** There will inevitably be a need over time for the approach to contractual specifications and payment mechanisms to shift to reflect the focus on outcomes – however the need for these to be evolutionary rather than revolutionary is recognised, with clear mechanisms in place to address system risks

Developing the neighbourhood model in Southwark

A key aim of the integration strategy is to develop local networks that can provide person focussed co-ordinated care to those in need of support. This is summarised in the extract from the Recovery Plan below, and will be developed alongside the introduction of the Anticipatory Care model anticipated during 2022/23 as set out in section 5.

Further work to embed this approach will be articulated in the Health & Care Plan during 2022/23 as part of our system response to the Fuller Review.

5. Implementing the BCF Policy Objectives (national condition four)

National BCF Priorities

The BCF plan is aligned to the new twin priorities set in the July guidance as follows:

- **Enable people to stay well, safe and independent at home for longer** – through the funding of person centred community based services that prevent the deterioration of health and wellbeing and help reduce avoidable admissions to hospital or care homes. BCF funded schemes include:
    - Home care
    - Step up reablement and intermediate care including urgent response
    - Support to carers
    - Telecare and community equipment
    - VCS funding
    - Falls service incorporated into BCF from 22/23
    - Self-management funding for people with long term conditions
    - Flexi care

- **Provide the right care in the right place at the right time** – through the funding of timely and effective hospital discharge services including:
    - 7 day hospital discharge team
    - Internal flow hubs pursuing home first discharge to assess approach
    - Community Health @home service (hospital at home)
    - Step down reablement and intermediate care
    - Home care
    - Residential care and nursing care

Further development areas for reducing delayed transfers: High Impact Changes Model for transfers of care

The High Impact Changes Model is a framework for identifying potential improvements across key aspects of the hospital discharge process. The model is used as a tool in Southwark as a benchmark for good practice and to help identify service improvement priorities. A recent assessment against the criteria confirmed that current arrangements fall into the mature or established banding. Areas for potential further improvement to be explored include:

Change 1: Early discharge planning

- ensure people at high risk of admission have discharge plans in place
- ensure full compliance with the setting of expected dates of discharge and ensuring effective communication of this
- ensure new providers implement the red bag scheme promptly

Change 2: Monitoring and responding to system demand and capacity

- further develop analysis of demand and capacity to enable more sophisticated and long range forecasting

Change 3: Multi-disciplinary (MDT) working

- primary care involvement in the MDT for discharge planning

Change 4: Home first / discharge to assess

- ensure nursing capacity in the community to do complex assessments
- further develop reablement and rehabilitation offer in terms of response times and level of care

Change 5: Flexible working patterns

- review need and costs/ benefits of expanded 7 day working across more teams in trusts, providers and community health
- enable more care packages to start at weekends

Change 6: Trusted assessment

- ensure Trusted Assessor model is fully embedded

Change 7: Engagement and choice

- choice protocol to be further refined and updated to reflect instances where there is limited choice available

Change 8: Improved discharge to care homes

- enable more weekend discharges to care homes

Change 9: Housing and related services

- ensure expected dates of discharge incorporate housing related needs

Actions arising from the **100 day challenge** exercise undertaken by trusts to improve transfers of care will be incorporated into improvement plans.

The BCF will be aligned with **winter planning** for 2022/23, particularly in terms of the focus of resources on minimising delayed transfers of care. This will include consideration of projected **demand and capacity for intermediate care** (provisional analysis included in template with this BCF submission to be built upon).

Further development areas for 2022/23 to deliver admissions avoidance objectives

Population health and Core20PLUS5: It is a priority to identify capacity to develop the Core20PLUS5 approach in 2022/23, working with ICS analytics teams to identify key population groups to target improvements in heath inequalities. This is likely to compliment the current Vital 5 strategy which focuses on people with key risk factor for poor health outcomes. (See also section 8, health inequalities)

Same day emergency care: The developing same day emergency care strategy will make a significant contribution to the BCF target for the reduction in avoidable emergency admissions.

Anticipatory Care and neighbourhood model development: Anticipatory Care is an NHS Long Term Plan commitment that aims to provide proactive and personalised health and care for individuals living with multiple long-term conditions, delivered through multidisciplinary teams in local communities. It aims to reduce avoidable admissions and improve outcomes by intervening earlier, proactively, and more holistically, whilst the patient is at home. A national framework for local implementation is in development that is expected to be finalised during the period of this plan. Southwark has undertaken a baseline

assessment of its preparedness for the introduction of Anticipatory Care and will develop a more detailed implementation plan building on the strengths of its current neighbourhood model arrangements in response to the framework.

BCF metrics and targets 2022/23

As set out in the detailed finance and metrics BCF template there are 4 main targets for 2022/23 that reflect delivery of objectives:

Avoidable admissions to hospital (unplanned admissions for chronic ambulatory care sensitive conditions)

Southwark has a relatively high rate of avoidable admissions on this metric, with the main related conditions being COPD, congestive heart failure and asthma. Taking into account benchmark rates an aspiration to reduce this by 5% is proposed with key drivers for improvement including:

- Improved Primary Care Access
- Care co-ordination at a neighbourhood level aimed at people identified as being at risk of admission
- Promoting self-management of long term conditions (BCF funded self-management courses being reviewed and re-commissioned)
- Development of same day emergency care as alternative to admission

Discharge to usual place of residence

Southwark has a comparatively very high rate of 97% on this metric reflecting a strong home first approach. It is not considered appropriate to aim to increase this further as for some discharges there is potential scope to better meet people's needs by discharge to specialist step down beds.

Permanent admissions to care homes

The target set reflects an increase from 140 to 162 permanent admissions. This is a stretching target because based on last year's data, increased demand for services and increased acuity of need, the year-to-date data and high levels of growth in activity in the pre-admission pipeline, it is forecast that there will be a significant increase in 2022/23.

Effectiveness of re-ablement

The target proportion of people still at home 91 days after discharge from hospital into reablement services remains set at 83%. This is considered an optimal balance given levels of acuity of people entering the service.

6. Supporting unpaid carers.

Funding from the BCF for carers and Care Act duties

A total of £1.95m of BCF funding is targeted at carers and Care Act duties.

The BCF from its inception in 2015/16 has included an allocation of £1m from the NHS minimum contribution to the council to meet additional costs arising from the Care Act.

In addition, £400,000 is allocated to the local VCS (Southwark Carers) for the provision of respite and £450,000 for the costs of carers assessments and services. From 2021/22 an additional £100,000 of annual uplift was targeted at the identified priority area of supporting carers of people with dementia.

Services

There are currently estimated to be 25,700 carers in Southwark

The Voluntary Community Sector (VCS) support for carers, provides information and advice on carers rights, advocacy, accessing grants, legal advice, employment information and advice, accessing statutory services and contingency planning. Carers can access one to one emotional support, as well as enjoy a range of activities and groups, trips and outings, for wellbeing, social interaction and peer support.

Imago is a dedicated service for young carers, which provides emotional and practical support to young carers with caring responsibilities. Imago is funded from the council's general fund to support (currently) 223 young carers registered in Southwark, 53 of which have been supported through one to one activities (workshops, respite, etc) in the past year.

Both Imago and commissioned Voluntary Community Sector (VCS) providers delivery resources for professionals in health, education and social care to improve identification of "hidden" carers and to raise awareness of the impact of caring.

Southwark has commissioned ADASS Proud to Care online scheme to provide a wide range of discounts to paid and unpaid carers in Southwark amongst other boroughs. Southwark is able to add local businesses to the scheme. Unpaid carers receive assistance from the Voluntary Community Sector to access the scheme.

As of February 2022, carers and foster carers in Southwark have access to a 24 hour helpline which offers confidential, professional support and advice around; health and wellbeing, money worries, self-care and respite, consumer and legal issues, family and home, work and life.

Carer training

The Institute of Public Care has recently been selected to facilitate carer training for staff across ASC, Aging Well Southwark and Commissioning. The workshops, which will be co-produced with Carers and representatives from the voluntary sector. They will embed the ethos and approach established by the Carer Pathway project, developing staff to;

- Understand and overcome the challenges to carer identification.
- Have skilled strengths based conversations, supporting carers to access resources to sustain the caring relationship and their own wellbeing.
- Use a more creative and person centred approach to support planning and use of direct payments

7. Disabled Facilities Grant (DFG) and wider services

The DFG service is based within Southwark Council's Private Sector Housing & Adaptations Team and delivered through the Home Improvement Agency (HIA). It is funded by a ring-fenced grant paid to the council for the discharge of its statutory duties to administer a DFG scheme. The DFG supports people with disabilities who are owner-occupiers (who may be asset rich and cash poor) and tenants of private rented/housing association housing by funding physical adaptations to their homes that enable them to remain long term in their own home in the community, avoiding admissions to hospital and care homes. As well as major adaptations the DFG also funds a handyperson service which works closely with the hospital discharge teams to enable people to return home from hospital when their house needs minor repairs. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes.

The Disabled Facilities Grant has a budget of £1.686m for 2022/23. This is the same allocation of funding as in 21/22, in real terms this can be seen to be a decrease in funding with the rise in costs of materials etc. Growth has been focussed on securing an increase in senior occupational therapist capacity to reduce delays and increase the number of people accessing DFG's.

In 22/23 the focus has been working on clearing the backlog of cases and dealing with any urgent / emergency cases. The financial means test for DFG applications continues to be temporarily waived. The overall delivery process has also been reviewed and improvements implemented. Financial counsellors continue to support applicants and provide assurance with safety etc.

Due to the high demand for grantss and the impact of the pandemic the HIA had to put in place a waiting list. There are currently 53 cases on the waiting list a reduction from 100 cases in 21/22. The team continues to work to reduce those on the waiting list.

From April 2022 to date, we have completed 35 major adaptations, of which 24 were for level access showers and 3 for stairlifts.

The DFG Service works with adult social care by having joint meetings bi-monthly to specifically discuss complex cases and every 3 months to discuss the progress of cases, staffing etc

Other specific areas of improvement:

- The DFG service is in the process of employing a Senior Occupational Therapist. This will help increase the number of OT assessments, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues.
- The DFG service continues to work with a fast track system that has been put in place to ensure cases assessed as urgent or end of life are prioritised.
- The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation

The case studies below illustrate how DFGs can benefit service users:

Ms N (37) suffers with dispraxia, curvature of spine, knee and hip problems. Her condition impacted on her general wellbeing as she unable to do what she would like to and when. The Occupational Therapist (OT) recommended a level access shower for Ms N. The HIA Financial Counsellor completed the DFG Grant application, liaised with surveyor and contractor to see the OT recommendation to reality. Ms N was very appreciative for the adaptations as it has given her independence in showering, as it had been years in which she was able to use her bathroom. Ms N has children and so this has given her a new lease of life with her family.

Ms J (83) has arthritis and muscular degeneration which has made her very dependent on family members to care for her personal needs and independence. This was becoming a more challenging situation for Ms J. The OT recommended a level access shower and level flooring between all doors in the home. Ms J lives in a HA property and they did not have the funds to adapt their property for the tenant and so this was passed to the HIA to address. The HIA Financial contacted the Ms J's granddaughter and completed the grant application, requested for a surveyor and contractor to be appointed for Ms J case and the works were completed. Ms J's granddaughter reported that the works completed by the HIA have aided not just Ms J but the whole family as they do not have to worry about Ms J having slips and falls in the property and Ms J can shower independently improving her feel good factor.

Mrs C (61) lives in a HA property and lives with her husband. She suffers with parkinsons, anxiety and depression. With these conditions Mrs C was unable to use her bathroom. An OT recommended a LAS and the HIA Financial Counsellor coordinated the grant application process with Mrs C's nephew, surveyor and contractor. Mrs C's nephew reported that her circumstances were progressively getting worse due to her inability to use the bathroom. This was addressed through the assistance of the HIA and Mrs C's nephew stated "the works helped significantly, and have had a huge impact on her day to day life as she showers easily with no difficulties".

Wider joint working with housing, health and social care

The Partnership Southwark neighbourhood model identifies a wide range of statutory and voluntary services that have a role in helping people improve their outcomes. Housing is key within this - and is an especially important partner in Southwark given the high levels of social housing, particularly amongst older people.

Housing services are engaged in Partnership Southwark's population-based programmes where housing issues are relevant to a particular workstream/project and the Partnership Southwark programme team are a core member of the Housing and Social Care Partnership Board.

Specific examples of joint working include:

- The BCF provides additional resources to have a housing advice officer working within the hospital discharge teams with the objective of addressing housing related delays as effectively as possible. This has been a considerable success and rolled out as an example of good practice.

- There is a strong link between housing, adults social care and health with regards to the BCF funded telecare services which the Housing department provides. For example, the telecare service provides pendant alarms, enabling a response to people who have fallen to be provided that reduces avoidable ambulance call-outs. This includes the use of emergency lifting cushions where necessary to assist the faller.
- The ICES equipment issued also helps people live in their home with more minor adaptations (e.g. bath rails) that complement the major adaptions offer
- The ongoing development of joint commissioning arrangements for supported housing and supported living arrangements for adults with complex needs, and extra care facilities for older people as an alternative to care homes.
- Close working between the council and health on the refugee and asylum seekers agenda
- During the pandemic there were many examples of proactive integrated working between health, housing and social care which we wish to build on. For example, in relation to homeless hotels and the vaccination programme in hostels.

8. Equality and health inequalities

Supporting the Southwark Health and Wellbeing Strategy

The drive areas included in the refreshed Southwark Health and Wellbeing Strategy agreed by the Health and Wellbeing Board in July 2022 are set out below. These form a basis for tackling health inequalities in Southwark.

Drive 1: A whole-family approach to giving children the best start in life

Focused on ensuring families receive care that works for them during pregnancy and a child's first years, and good mental health support for the whole family

Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy

Focused on improving access to good quality jobs through our employment and procurement practices and helping working age adults to lead healthy lifestyles

Drive 3: Early identification and support to stay well

Focused on keeping people well as they age through prevention, early detection and intervention, and support for carers

Drive 4: Strong and connected communities

Focused on shaping services with communities, tackling isolation and ensuring services are accessible to all

Drive 5: Integration of Health and Social Care

Focused on joined-up, person-centred care, good governance and making the best use of the Southwark pound

The key areas in which the BCF will support the refreshed Health and Wellbeing Strategy are as follows:

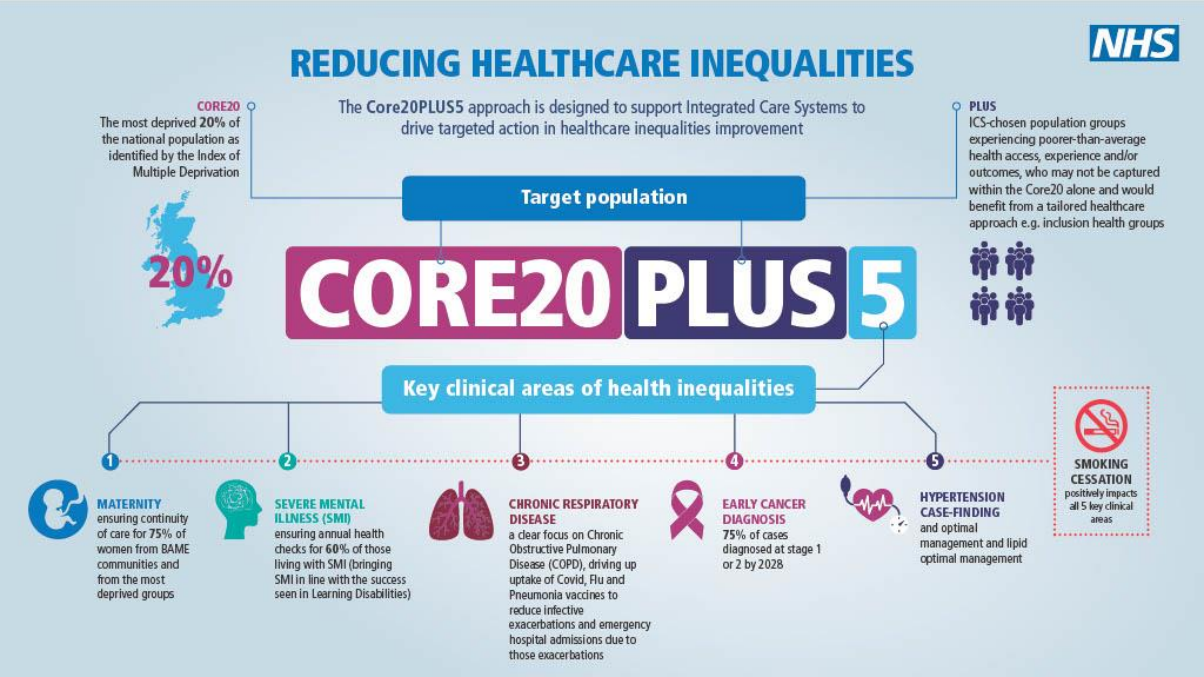
Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy: the BCF provides funding for costs associated with the Southwark ethical care charter, which helps ensure good employment practices in commissioned services.

Drive 3: Early identification and support to stay well: The BCF funds a number of services that have preventative value including the voluntary sector hub, falls prevention, self-management for people with long term conditions and telecare. Also captured under this heading is a range of core out of hospital services funded through the BCF such as rehab and reablement, carers support and hospital discharge support.

Drive 4: Strong and connected communities: BCF funding supports the voluntary sector hub which play a key role supporting strong communities. The vision for integration which the BCF supports includes the development of a strong neighbourhood model which would help promote community resilience.

Drive 5: Integration of Health and Social Care: The BCF is a key pooled budget providing a foundation for the alignment of resources as an enabler of integration. It funds services that have become more integrated e.g. Reablement and Community Health enhanced rapid response have integrated as Intermediate Care Southwark. The **Health and Care Plan** and an associated outcomes framework will be developed over 2022/23 to provide detail on the delivery of this drive area. The BCF will be fully aligned with this plan.

Core20PLUS5: As referenced in relation to reducing avoidable admissions, it is a priority to develop the Core20PLUS5 approach in 2022/23, working with NHS analytics teams and public health to identify key population groups to target improvements in heath inequalities. This is likely to compliment the current Vital 5 strategy which focuses on people with key risk factor for poor health outcomes. The Core20PLUS5 approach is illustrated in the diagram below:



Partnership Southwark Recovery Plan – focus on inequalities

The Partnership Southwark Recovery Plan sets out the wide range of inequalities in outcomes experienced by Southwark's population which were highlighted and exacerbated by the differential impact of COVID-19 on communities. Addressing inequalities is at the heart of the partnership's 4 key population-based programmes:

Addressing Inequalities actively listening and responding to partners and residents in support of Southwark Stands Together and in building broader community engagement			
Safeguarding our communities and those who support them mitigating and managing any second wave of COVID-19 with dedicated support to those who are vulnerable or at risk			
Start Well supporting children and young people - "keeping families strong"	**Live Well** supporting working age adults with joined up services that tackle the causes of ill-health and promote wellbeing	**Age Well** neighbourhood-based networks to keep people as healthy and independent as possible in their home	**Care Well** supporting those in care and residential settings for older people and physical disabilities, mental health and learning disabilities

The BCF funding is a key enabler of the adult's focused live well, age well and care well workstreams, funding a significant range of community based health and care services that are working together to deliver the objectives of the plan.

The Partnership is committed to a data driven population health approach to addressing inequalities. It draws on intelligence and recommendations from the Covid 19 JSNA and the guiding principles of the health inequalities framework both of which have been shaped and informed by a range of stakeholders from within the partnership.

Contribution to Equalities Act requirements

The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom are reliant on these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of BCF investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities.

Example of BCF funded services contributing to equalities aims: Behavioural Support

The Behavioural Support scheme has been funded in 2022/23 for £100k. This scheme supports younger people with learning disabilities and challenging behaviour to remain in the community through the provision of enhanced psychological support, avoiding placement breakdown and the need to enter more restrictive placements including secure inpatient settings. This is a group with poor health and wellbeing outcomes that the BCF scheme will help address by enabling a more preventative "all ages" approach.

The London Borough of Southwark Positive Behaviour Service (LBS PBS) has an operational policy with pre/post intervention survey.

A Clinical Psychologist has been recruited by LBS that will support the LBS PBS offer and deliver preventative interventions with the team. The PBS team (2 x PBS workers funded by the £100k BCF money and a Clinical Psychologist - funded by LBS) are supporting Complex cases. These are AAD clients who are at risk of placement breakdown/hospital admission.

The Dynamic Support Register (DSR) will be utilised to accurately log Southwark clients escalation as well as de-escalation (red, amber, green). This will underpin the outcome measurements and help determine the effectiveness of the service.

Annex 1 – full summary of BCF changes 2021/22 to 2022/23

Better Care Fund - 2022 -2023

Description	Final Annual Plan 21-22 £	Additional contributions/changes £	Uplift 2022/23 £	Draft Plan 2022/23 £
Local Authority				
Community Support				
Dementia - Enhanced Neighbourhood Support	184,177			184,177
Homecare Quality Improvement	1,900,000			1,900,000
Residential & Nursing	1,871,339			1,871,339
Protect Adult Social Care - Residential Care	2,010,610			2,010,610
Reablement & Nursing Support Pressures	0	0	263,000	263,000
Total Community Support	**5,966,126**	**0**	**263,000**	**6,229,126**
Hospital Discharge				
Contingency - council staff	300,000			300,000
Discharge to Assess - Council Costs	260,000		250,000	510,000
Reablement - OT Team	0		455,885	455,885
Hospital discharge	1,790,453			1,790,453
Housing Worker Discharge Team	50,000			50,000
Intermediate Care	1,137,563			1,137,563
Night Owls - overnight intensive homecare	224,000			224,000
Reablement	1,936,738			1,936,738
Total Hospital Discharge	**5,698,754**	**0**	**705,885**	**6,404,639**
Mental Health & Wellbeing				
Community Mental Health Services	655,000			655,000
Enhanced Psychological Support for those with LD	29,000			29,000
Learning Disability - Personal Budgets	211,000			211,000
Mental Health Reablement	151,632			151,632
Mental Health - Personal Budgets	600,000			600,000
Mental Health Broker	60,000			60,000
Mental Health Complex Cases Worker	50,000			50,000
Mental Health Discharge Worker	50,000			50,000
Psychiatric Liaison (AMHPs and reablement)	300,000			300,000
Total Mental Health & Wellbeing	**2,106,632**	**0**	**0**	**2,106,632**
Misc				
Care Act Funding	1,000,000			1,000,000
Service Development and Change Management	45,000			45,000
Total Misc	1,045,000	0	0	1,045,000
Prevention				
Carers Strategy	450,000			450,000
Unpaid Carers	100,000			100,000
Community Equipment	562,000	246,850		808,850
Telecare	566,000	444,626	57,995	1,068,621
Voluntary Sector Prevention Services	1,248,251	482,749		1,731,000
Voluntory Sector Carers work	400,000	113,000		513,000
Total Prevention	**3,326,251**	**1,287,225**	**57,995**	**4,671,471**
London Borough of Southwark	**18,142,763**	**1,287,225**	**1,026,880**	**20,456,868**
South East London CCG - Southwark				
Mental health and Learning Difficulty				
Enhanced Intervention Service	218,403		5,962	224,365
Total Mental health and Learning Difficulty	**218,403**	**0**	**5,962**	**224,365**
Admission Avoidance				
Admissions avoidance - ERR and @home	4,644,157		78,951	4,723,108
GP Support @ Home Acuity	0	0	253,500	253,500
@Home Geriatric Assessment	0	0	30,000	30,000
@Home Integrated Care Fellows		82,500		82,500
@ Home Nursing Expansion		108,788		108,788
Falls Service - Expansion of BCF		820,832		820,832
Care home pharmacist	47,095	-47,095		0
Enhanced primary care access	743,000	-743,000		0
Self-management	327,347	-110,140		217,207
Total Admission Avoidance	**5,761,599**	**111,885**	**362,451**	**6,235,935**
Hospital Discharge				
Neuro-rehab team - GSTT	193,728		3,293	197,022
Total Hospital Discharge	**193,728**	**0**	**3,293**	**197,022**
Prevention				
ICES	420,518	1,200,520	25,909	1,646,947
Behavioural Support LD & Autism	100,000			100,000
Total Prevention	**520,518**	**1,200,520**	**25,909**	**1,746,947**
Service Development				
Service development (50% CCG element)	330,758			330,758
Total Service Development	**330,758**	**0**	**0**	**330,758**
SEL CCG - Southwark	**7,025,006**	**1,312,405**	**397,615**	**8,735,026**
Total Better Care Fund - CCG contribution & additional funds	**25,167,769**	**2,599,630**	**1,424,495**	**29,191,895**
Other Local Authority				
Disabilities Facilities Grant	1,686,144			1,686,144
IBCF*	17,322,581		524,768	17,847,349
Total Other - Local Authority	**19,008,725**	**-**	**524,768**	**19,533,493**
Total Better Care Fund	**44,176,494**	**2,599,630**	**1,949,263**	**48,725,388**

*The full use of the IBCF grant is now as set out below;

IBCF Grant 2022/23 (Council)

Home Care	£11,198,498
Nursing Care	£4,474,334
Reablement and Intermediate bed based care	£999,749
Residential care for older people	£400,000
Transformation Fund	£250,000
IBCF Flexicare (22/23 growth)	£524,768
Total IBCF	**£17,847,349**